House of Representatives

General Assembly

File No. 257

January Session, 2005

Substitute House Bill No. 6654

House of Representatives, April 11, 2005

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING SMALL BUSINESS ACCESS TO HEALTH INSURANCE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivisions (5) and (6) of section 38a-567 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(5) (A) With respect to plans or arrangements issued on or after July 1, 1995, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

[(i) Age, provided age brackets of less than five years shall not be utilized;**]**

[(ii)**]** (i) Gender;

[(iii)**]** (ii) Geographic area, provided an area smaller than a county shall not be utilized;

[(iv)**]** (iii) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

[(v)**]** (iv) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

[(vi)**]** (v) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions; and

[(vii)**]** (vi) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; **[**and**]** or (VI) employee plus two or more dependents.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall

apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on **[**age and other**]** demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

Sec. 2. Section 38a-568 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) (1) **[**Subject**]** Except as provided in subdivision (2) of this subsection, and subject to approval by the commissioner, the board shall establish the form and level of coverages to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Such coverages, which shall be designated as small employer health care plans, shall be limited to: (A) A basic hospital plan, (B) a basic surgical plan, (C) major medical plans which can be written in conjunction with basic hospital plans or basic surgical plans, (D) comprehensive plans, and (E) plans with benefit and cost-sharing levels which are consistent with the basic method of operation and the benefit plans of health care centers, including any restrictions imposed by federal law. The board shall submit such plans to the commissioner for the commissioner's approval not later than ninety days after the appointment of the board pursuant to section 38a-569. The board shall take into consideration the levels of health

insurance provided in Connecticut and such medical and economic factors as may be deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of health insurance provided to small employers. Such plans may include cost containment features including, but not limited to: (i) Preferred provider provisions; (ii) utilization review of health care services, including review of medical necessity of hospital and physician services; (iii) case management benefit alternatives; and (iv) other managed care provisions.

(2) Notwithstanding the provisions of this section, not later than January 1, 2006, the board shall establish an additional small employer health care plan to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Notwithstanding the provisions of this chapter, the additional plan shall be designed to: (A) Offer choices among provider networks of different size; (B) offer different deductibles depending on the health care facility used; (C) use both deductibles and coinsurance; (D) offer prescription drug benefits that use any combination of deductibles, coinsurance and copayments, including, but not limited to, policies and plans that use different combinations at different benefit levels; and (E) offer fewer benefits than required under this chapter. The board may take into consideration the levels of health insurance provided in Connecticut and such medical and economic factors as may be deemed appropriate. Such plans may include the cost containment features set forth in subdivision (1) of this subsection.

[(2)**]** (3) After the commissioner's approval of small employer health care plans submitted by the board pursuant to subdivision (1) or (2) of this subsection, and in lieu of the procedure established by section 38a-513, any small employer carrier may certify to the commissioner, in the form and manner prescribed by the commissioner, that the small employer health care plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after

notice and hearing, disapproves their continued use.

(b) Not later than ninety days after the commissioner's approval of small employer health care plans submitted by the board, each small employer carrier, including, but not limited to, each health care center, shall, as a condition of transacting such insurance in this state, offer those small employer health care plans that correspond to the insurance products being currently offered by the carrier to small employers. Each small employer that elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier.

(c) No health care center shall be required to offer coverage or accept applications pursuant to subsection (b) of this section in the case of any of the following: (1) To a group, where the group is not physically located in the health care center's approved service area; (2) to an employee, where the employee does not work or reside within the health care center's approved service area; (3) within an area, where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (4) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition; or (5) where the commissioner finds that compliance with subsection (b) or (f) of this section would place the health care center in an impaired financial condition. A health care center that refuses to offer coverage pursuant to subdivision (3) of this subsection may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees.

(d) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (b) of this section subject

to the following conditions: (1) The small employer carrier ceases to market health insurance or health benefit plans to small employers and ceases to enroll small employers under existing health insurance or health benefit plans; (2) the small employer carrier notifies the commissioner of its decision to cease marketing to small employers and to cease enrolling small employers, as provided in subdivision (1) of this subsection; and (3) the small employer carrier is prohibited from reentering the small employer market for a period of five years from the date of the notice required under subdivision (2) of this subsection.

(e) For groups containing only one member, a small employer carrier or health care center offering coverage pursuant to this section may require proof that the individual has been self-employed for three consecutive months.

(f) Each small employer carrier, including, but not limited to, a health care center, shall offer each health care plan that the carrier makes available to small employers, except association group plans, to all small employers, including, but not limited to, groups containing only one member.

Sec. 3. (NEW) (*Effective October 1, 2005*) Any licensed health insurer or health care center may design and issue health insurance policies or plans that offer flexible benefits designed to reduce health insurance premiums or fees provided such policies or plans meet the requirements of title 38a of the general statutes. Such policies and plans may include, but need not be limited to, policies and plans that: (1) Offer choices among provider networks of different size; (2) offer different deductibles depending on the health care facility used; (3) use both deductibles and coinsurance; or (4) offer prescription drug benefits that use any combination of deductibles, coinsurance and copayments, including, but not limited to, policies and plans that use different combinations at different benefit levels.

Sec. 4. (NEW) (*Effective October 1, 2005*) Not later than January 1, 2006, and annually thereafter, each physician licensed pursuant to chapter 370 of the general statutes shall provide the Insurance

Commissioner with a list of the usual and customary fee charged by the physician for office visits and for any medical service or procedure the physician performs. The physician shall file the information on such form as the commissioner prescribes. The commissioner shall compile the data and publish the data on the department's Internet website.

Sec. 5. (*Effective from passage*) (a) Not later than October 1, 2005, the Insurance Commissioner shall convene a working group to develop a comprehensive provider quality database. The working group shall consist of the Commissioner of Public Health, the Commissioner of Health Care Access, health care providers and consumers, representatives of health insurers and health care centers licensed in this state, and representatives of employers that provide health insurance to residents of this state.

(b) The working group shall examine the information collected from providers and disseminated to the public pursuant to the physician profile created under section 20-13j of the general statutes. The working group shall examine (1) whether additional information should be collected and disseminated, and (2) what other mechanisms are available or may be created to provide greater public information about the level of expertise of individual providers in this state.

(c) Not later than February 1, 2006, the Insurance Commissioner shall submit a report on the working group's findings to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health in accordance with section 11-4a of the general statutes.

Sec. 6. Subdivision (7) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) accident only,

credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by **[**age,**]** gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

Sec. 7. Subdivision (27) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(27) "Case characteristics" means demographic or other objective characteristics of a small employer, including **[**age,**]** sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2005*	38a-567(5) and (6)
Sec. 2	*October 1, 2005*	38a-568
Sec. 3	*October 1, 2005*	New section
Sec. 4	*October 1, 2005*	New section
Sec. 5	*from passage*	New section
Sec. 6	*October 1, 2005*	38a-564(7)
Sec. 7	*October 1, 2005*	38a-564(27)

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 06 $	FY 07 $
State Comptroller - Fringe Benefits	None	None	None
Insurance Dept.	IF – Potential Cost	27,596	34,425

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill eliminates age as a rating factor for small employer health insurance plans and has no impact to the state or municipal employee health plans.

There could be a slight increase in the number of rate and form filings as a result of the bill. To the extent that there is such an increase, the Department of Insurance could incur costs of $27,596 in FY 06 and $34,425 in FY 07, (which includes fringe benefits) for an one-quarter actuary to review the increased volume of rate and form filings.

OLR Bill Analysis
sHB 6654

AN ACT CONCERNING SMALL BUSINESS ACCESS TO HEALTH INSURANCE

SUMMARY:
By law, rates for small employer health insurance must be based on a community rate, adjusted for one or more specified factors. This bill eliminates age as one of those factors. Thus, rates for small employers (50 or fewer employees) cannot be based on age.

The bill requires the Connecticut Small Employer Health Reinsurance Pool's board of directors, by January 1, 2006, to develop a health care plan with a flexible benefit design that insurers can offer to small employers. It also permits licensed health insurers and HMOs to design and issue plans that offer flexible benefit designs.

The bill requires each licensed physician to give the insurance commissioner a list of his usual and customary charges for office visits and medical services. The list must be filed, on a form the commissioner prescribes, annually beginning January 1, 2006. The commissioner must publish the information on the department's Internet web site.

The bill also requires the commissioner, by October 1, 2005, to convene a working group to develop a provider quality database. She must report the group's findings to the Public Health and Insurance and Real Estate committees by February 1, 2006.

EFFECTIVE DATE: October 1, 2005, except the working group provisions, which are effective upon passage.

FLEXIBLE BENEFIT DESIGNS

Small Employer Plan

The plan established by the reinsurance pool board must use both deductibles and coinsurance and offer:

1. a choice of different size provider networks;

2. different deductibles depending on the health care facility used;

3. fewer benefits than small employer plans are currently required to include; and

4. prescription drug benefits that use any combination of deductibles, coinsurance, and copayments, including different combinations at different benefit levels.

The plan can include cost containment features, such as preferred provider requirements, utilization review, case management, and other managed care provisions. In developing the plan, the board can consider the levels of health insurance provided in Connecticut and medical and economic factors it deems appropriate.

Other Plans

A health insurer- or HMO-designed flexible benefit plan can use both deductibles and coinsurance and offer (1) a choice of different size provider networks; (2) different deductibles depending on the health care facility used; and (3) prescription drug benefits that use any combination of deductibles, coinsurance, and copayments, including different combinations at different benefit levels.

WORKING GROUP

Members

The provider quality database working group must consist of (1) the public health commissioner, (2) the health care access commissioner, (3) health care providers, (4) health care consumers, (5) representatives of Connecticut-licensed insurance companies and HMOs, and (6) representatives of employers that offer health insurance to Connecticut residents. Although not specified, the insurance commissioner is apparently also a member.

Provider Quality Database

The working group must examine the Department of Public Health's (DPH) physician profile to determine (1) if additional information should be collected and published and (2) other ways to inform the

public of provider expertise.

BACKGROUND

Adjusted Community Rating

Community rating is the process of developing a uniform rate for all enrollees. Connecticut law requires insurers to use adjusted community rating for small employer groups (50 or fewer employees) by developing a community rate then adjusting it for specific case characteristics. Under current law, "case characteristics" means demographic or other objective characteristics of a small employer group's employees, including age, gender, family composition, location, size of group, industry classification, and administrative cost savings resulting from the administration of an association group plan or a plan written through the municipal employee health insurance plan (MEHIP), which is arranged by the comptroller.

Connecticut Small Employer Health Reinsurance Pool

The Connecticut Small Employer Health Reinsurance Pool, whose members are health insurers issuing health insurance and insurance arrangements providing health plan benefits, reinsures insurers who wish to relinquish liability for a small employer's employees' or dependents' covered expenses over $5,000 per covered person. The pool selects a board of directors, subject to the insurance commissioner's approval, to administer the pool. The board is required to develop special health care plans it deems appropriate for health insurers and HMOs to issue to small employers.

Physician Profile

DPH's physician profile contains information about (1) the physician's medical education and practice, (2) disciplinary actions taken and medical malpractice claims made against him, and (3) criminal felony convictions in the last 10 years. A physician can choose to omit information on medical school appointments, publications, and professional activities and awards. DPH must publish the profiles on an Internet web site.

Related Bills

sHB 6655 adds certain savings as a factor that can be used when

developing small employer premium rates. It specifies that the small employer rating law does not apply when the comptroller or an association group plan seeks to arrange coverage for 3,000 or more individuals from an insurance carrier. It also excludes from the small employer definition (1) any group that contributes to the 3,000 or more individuals and (2) community action agencies.

sSB 1034 excludes community action agencies from the definition of small employer and permits licensed insurers and HMOs to offer plans with flexible benefit designs.

SB 131 adds to the information that a physician must submit to the DPH physician profile. It also requires physicians to notify the DPH of any profile changes within 60 days of the change.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 9 Nay 7